PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

04500

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, Institution, or street address where death occurred:
W. Loo Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 64 W. Loo
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Levi Anthony

3.(b) Social Security Number: 217-10-4943

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 27, 1873

8. AGE: Years	Months	Days	If less than one day
71	9	24	..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany Cty., Md.
(Town, county, and state)

10. Usual occupation: Sweeper

11. Industry or business: Celanese plant

FATHER
12. Name: Gerson Anthony.
13. Birthplace: Wales

MOTHER
14. Maiden name: Rachel Llewellyn.
15. Birthplace: Wales

16. Informant: Harry Hitchins.
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: J. J. Durst.
Address: Frostburg, Md.

19. 5-24 19 45 Mrs. Nancy H. Poe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21st., 1945, at about 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Prince H. Brown, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 5-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

04501

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs 11 mos 20 dys

Hospital, institution, or street address where death occurred:

B. & O. Ry – Evitts Crk. Bridge

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 516 Laing Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Joseph Edward Appel.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10 1937

8. AGE:

Years	Months	Days	If less than one day
7	11	20	hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Schoolboy

11. Industry or business:

FATHER — 12. Name: Harry Appel.

13. Birthplace: Little Orleans Md.

MOTHER — 14. Maiden name: Gladys Pinker

15. Birthplace: Lost City W. Va.

16. Informant: Mrs Gladys Appel.

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1 45 (month) (day) (year)

Cemetery or crematory: Mt Hermon Cem.

Location: Appel – Cumberland Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. June 1 19 45 Miles R. Crantz M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30th 19 45 at 1.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fractured skull, Frontal bone.	Killed instantly
Due to:	
Due to:	
Other conditions: Fract. right ulna and radius, lower third.	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5-30-45

Where did injury occur? Near Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) R.R. Tracks

Means of injury: struck by locomotive Injured at work? no

23. SIGNATURE: Louis W. Bolton, M. D.

Address: Cumberland, Maryland. M. D. or other

Date signed: 5-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1707

CERTIFICATE OF DEATH

04502

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Info re Accident obtained from report from Coro. of M. V. 6/9/45

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital, Cumberland, Md.

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Somerset

City or town: Garrett
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles R. Ash

3.(b) Social Security Number 198-20-0918

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1926

8. AGE: Years	Months	Days	If less than one day
18	6	28	..... hrs. ..... min.

9. Birthplace: Penn. (Town, county, and state)

10. Usual occupation: Laborer Coal Mine

11. Industry or business: Eagle Coal Company

FATHER — 12. Name: Silas Ash

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Nellie Smith

MOTHER — 15. Birthplace: Md.

16. Informant: P. J. Brinker

Address: 517 Old Town Road, City.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-25-45 (month) (day) (year)

Cemetery or crematory: Garrett Cemetery

Location: Garrett, Pa.

18. Funeral director: W. A. Johnson

Address: Berlin Pa.

19. May 24, 1945 (Date rec'd by registrar) Winter R. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/22 1945 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/20, 1945, to 5/22, 1945 and that I last saw him alive on 5/22, 1945

Immediate cause of death	DURATION
Fractured base of Skull	
Due to Automobile accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: not consented to

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5/20/45

Where did injury occur? Near Friedman Pa. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public

Means of injury: Car run off roadway Injured at work? No

23. SIGNATURE: D. Kesler M. D. or other

Address: 12 Bedford St. Date signed: 5/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

04503

Reg. Diat. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 years
Hospital, institution, or street address where death occurred: Waterclife St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waterclife Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Thomas Barnes

3.(b) Social Security Number: 212-12-8114-A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of ~~husband~~ or wife: Ida May Patterson
B.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): July 10, 1889

8. AGE: Years: 85 | Months: 10 | Days: 20 | If less than one day: ....hrs. ....min.

9. Birthplace: Barton, Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Mechanic - Retired
11. Industry or business: West Va. Pulp Mill

FATHER
12. Name: George W. Barnes
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Virginia Lenty
15. Birthplace: Germany

16. Informant: John B. Barnes
Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 2 1945 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Oscar, Maryland

18. Funeral director: D. E. Eichhorn
Address: Lonaconing, Md.

19. May 31 1945 (Date rec'd by registrar) Dr. E. Dan Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 19 45 at 4 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 45, to May 30 19 45
and that I last saw h[er] alive on May 30 19 45

Immediate cause of death	DURATION
Arteriosclerosis	
Cerebral Thrombosis	14 mo.
Due to: Chr. Myocarditis	
Paralysis of Pharynx & Larynx	14 mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Norman Reeves, M.D.
M. D. or other
Address: Westernport, Md. Date signed: 5-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04504

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
679 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 679 Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Carl W. Bloss

3.(b) Social Security Number: 214-07-4333

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virgie Grove Bloss

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 30, 1884

8. AGE:	Years	Months	Days	If less than one day
	61	1	11	...hrs. ...min.

9. Birthplace: Seibert, Md.
(Town, county, and state)

10. Usual occupation: Celeanese Worker

11. Industry or business: Celeanese Corp. Of America

FATHER
12. Name: Charles Bloss
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Mary Hoover
15. Birthplace: Germany

16. Informant: Mrs. Virgie Bloss

Address: 679 Fayette St. Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May 14, 1935 (month) (day) (year)

Cemetery or crematory: HillCrest Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. May 14 45 Winter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1945, at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-11 1945, to 5-11 1945 and that I last saw h...e M...alive on 5-11 1945

Immediate cause of death	DURATION
Coronary thrombosis	3 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. B. Moore M.D.
M. D. or other

Address: Medical Bldg Date signed: 5-11-45

DR. BROADRUP

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 772

CERTIFICATE OF DEATH

04505

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County ALLEGANY

City or town FROSTBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No. GUNTER HOTEL (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR JOHN BONE

3.(b) Social Security Number 212-14-1971

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 30, 1892

8. AGE: Years	Months	Days	If less than one day
52	9	13	..... hrs. ..... min.

9. Birthplace MD. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business W. Md. R.R. Co.

FATHER
12. Name HENRY BONE
13. Birthplace MD.

MOTHER
14. Maiden name MARY PRESTON
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15-1945 (month) (day) (year)

Cemetery or ~~cemetery~~ Allegany

Location Frostburg

18. Funeral director J. F. Young Sons
Address Frostburg

19. May 14 1945 (Date rec'd by registrar) Walter A. Franz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13 19 45, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 9, 1945 19 ..... to MAY 13, 1945 and that I last saw him alive on ..... 19 .....

Immediate cause of death	DURATION
Uremic Alcoholism	3 years
Due to	
Due to	
Other conditions Delirium Tremens	4 days

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. T. Broadrup M.D. M. D. or other

Address Cumberland, Md. Date signed May 14, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Call Right

Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04506

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 46 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 342 Bedford Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Baby Boy Bonig

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1945

8. AGE: Years | Months: 1 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Charles H. Bonig
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary R. Simpson
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/30/45 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland Md

18. Funeral director: William H Light

Address: Cumberland, Md

19. May 29, 1945 (Date rec'd by registrar) Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1945, at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 12, 1945 to May 28, 1945

and that I last saw him alive on May 28, 1945

	DURATION
Immediate cause of death: Pandiac Collapse	Sudden
Due to: Diarrhea	1 mos.
Due to: Premature	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay R. Lumm M. D. or other

Address: Cumberland Date signed: May 29, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

T 04507

Reg. Dist. No. 4

VS A15 (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Christie Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Luther Bramble

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Hattie Wadsworth
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 24 1878

8. AGE: Years	Months	Days	If less than one day
67	3	21	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Cumberland Lumber Co.
FATHER 12. Name: Nathan Bramble
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Rice
15. Birthplace: Unknown
16. Informant: Mr. Charles Bramble
Address: 33 N. Mechanic St, Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Herman Cem.
Location: Near Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. May 19 1945 (Date rec'd by registrar) Hunter R Crouty MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 5/15 1945, at 10:03 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 24 1945 to May 15 1945 and that I last saw h alive on May 15 1945

Immediate cause of death	DURATION
Due to: Cerebral hemorrhage	6 hours
Due to:	
Other conditions: Hypertensive arterial hypertension	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. H. Sroczaski M.D. M. D. or other
Address: Cumberland, Md. Date signed May 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04508

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs.

Hospital, institution, or street address where death occurred:
229 Race St. Cumberland, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 229 Race St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Chester Eugene Brant

3. (b) Social Security Number: 214-05-9424

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Kathleen Cochran Brant

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 9. 1905

8. AGE: Years	Months	Days	If less than one day
39	9	21	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business: Bethelehelm Steel Co. Balto. Md.

FATHER
12. Name: Harry Brant
13. Birthplace: Cumberland, Md

MOTHER
14. Maiden name: Emma Rosenmerkle
15. Birthplace: Cumberland, Md.

16. Informant: Kathleen Brant.
Address: 229 Race St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. June 1, 1945 (Date rec'd by registrar) Winter R. Mauk, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30, 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 20, 1945, to May 30, 1945, and that I last saw h alive on May 30, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mon.
Tuberculous orchitis	8 mon
Cold abscess in Pelvis	3 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Orchidectomy, Right

Date of op. Apr. 20, 1945

Autopsy results: Cold abscess Pelvis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Jarrett M. D. or other

Address: Cumberland Date signed: 5/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. C. L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

1 04509

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 20 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County GARRETT
City or town GRANTSVILLE, MD., RT. 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME OTIS ODELL BROADWATER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

B.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 18, 1943

8. AGE:

Years	Months	Days	If less than one day
2	~~2~~ 0	16	..... hrs. ..... min.

9. Birthplace GRANTSVILLE MD., GARRETT CO.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name HARRY BROADWATER
13. Birthplace MD.

MOTHER
14. Maiden name VESPA BROADWATER
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial Date thereof May 7 1945
(Burial, cremation, or removal) Which? (Month) (Day) (year)
Cemetery or crematory Grantsville Cem
Location Grantsville, Md.

18. Funeral director Wm Winterberg, Jr.
Address Grantsville, Md.

19. May 7 1945 Winter L. Kantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 4 1945, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21st 1945, to May 4 1945
and that I last saw h.. alive on May 4th 1945

Immediate cause of death	DURATION
Meningo-Encephalitis	6 hrs.
Due to	
Due to	
Other conditions Convulsions	1 wk

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. L. Owens M.D.
M. D. or other
Address Cumberland Md. Date signed 5-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04510

Reg. Dist. No. 1

1. PLACE OF DEATH:
County: Allegany
City or town: Little Orleans (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 1 - LaVale
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Elton Dale Brown

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or wife: G. Sheldon Brown
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1913

8. AGE:

Years	Months	Days	If less than one day
32	3	14	— hrs. ... min.

9. Birthplace: Piney Grove, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own home

FATHER
12. Name: John A. Watson
13. Birthplace: Allegany Co. Md.

MOTHER
14. Maiden name: Mary E. Crawford
15. Birthplace: Fulton Co. Pa

16. Informant: Mary E. Watson
Address: Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8, 1945 (month) (day) (year)
Cemetery or crematory: Piney Plains Cemetery
Location: Little Orleans, Md. R.I.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. May 7 1945 (Date rec'd by registrar) Mrs. L. A. Hawkaly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1945, at 1245 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 4, 1945, to May 5 1945
and that I last saw h... alive on May 4 1945

	DURATION
Immediate cause of death: Pulmonary	
Due to: Tuberculosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op. None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 5-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04511

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
108 Va. Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 Race St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma R. Burkhart

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Charles C Burkhart

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 14 1871

8. AGE: Years	Months	Days	If less than one day
74	9	10	..... hrs. ..... min.

9. Birthplace: Somerset Co Pa
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: None

FATHER
12. Name: Jacob Lammerer
13. Birthplace: Pa

MOTHER
14. Maiden name: Elizabeth Solma
15. Birthplace: Pa

16. Informant: Daisy M. Burkhart
Address: Cumberland md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27 1945 (month) (day) (year)

Cemetery or crematory: Mt Zion Cem

Location: Mt Zion Pa

18. Funeral director: Louis Stein Inc.

Address: Cumberland md

19. May 26 1945 Walter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th, 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bruce H. Johnson M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 5-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1000)

CERTIFICATE OF DEATH

T 04512

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Lang Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Pearl Gertrude Bush

3.(b) Social Security Number 215-18-8318

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James Bush

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1896

8. AGE:

Years	Months	Days	If less than one day
48	8	11	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co., Md (Town, county and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name James Smith

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Edith May Ford

15. Birthplace Brunswick, Md.

16. Informant Mrs John Hull

Address 29 Oak St - Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland

18. Funeral director John J. Hafey

Address Cumberland, Md

19. May 15 1945 (Date rec'd by registrar) Winter P. Trantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945 to May 12 1945

and that I last saw her alive on May 12, 1945

Immediate cause of death	DURATION
Pulmonary Infarct	3 wks
Due to Fractured Femur	
Due to Phlebitis Right Femoral Vein	3 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clay L. Lucas M. D. or other

Address Cumberland Date signed 5/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

04513

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Alleg

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

610 Greenway Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Alleg

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 Greenway Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anthony C Buskey.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Griffin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25 1868

8. AGE:

Years	Months	Days	If less than one day
76	11	29	..... hrs. ..... min.

9. Birthplace Wisconsin (Town, county, and state)

10. Usual occupation Crane Operator - Retired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Mrs Mary Buskey

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28 1945 (month) (day) (year)

Cemetery or crematory St Mary's Cem.

Location Cumberland Md

18. Funeral director Louis Stein Sue

Address Cumberland Md

19. May 26 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 8-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945, to May 24 1945

and that I last saw h alive on May 20 1945

Immediate cause of death	DURATION
Arteriosclerosis	5 yrs
Due to Myocarditis	2 yrs
Due to Uraemia	3 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Chas R. Jones M. D. or other

Address Cumberland Date signed 5/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

04514

Reg. Dist. No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Potomac Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Potomac Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Carroll

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm H Carroll

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 13 1872

8. AGE: Years 73 Months 1 Days 4 If less than one day hrs. min.

9. Birthplace: Berkey West Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: John Burns

FATHER 13. Birthplace: West Va

MOTHER 14. Maiden name: Unk

MOTHER 15. Birthplace:

16. Informant: Harry W Carroll

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: near Cumberland Md

18. Funeral director: Davis Stein & Son

Address: Cumberland Md

19. May 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1945 at 12 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945 to May 17 1945 and that I last saw h alive on May 16 1945

	DURATION
Immediate cause of death: congestive heart failure	one year
Due to: chronic myocarditis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W Brinn M D

M. D. or other

Address: Lonaconing Md Date signed 5-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04515 9

Reg. Diat. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing (Eckhart) Frostburg R.F.D. 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.: L
(If rural, give LOCATION)
2.(a) If veteran, name war: L

3.(a) FULL NAME: Joseph Cesnick

3.(b) Social Security Number: L

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Lukas
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): December 13, 1875

8. AGE: Years	Months	Days	If less than one day
69	4	18	...hrs. ...min.

9. Birthplace: Hungary (Town, county, and state)
10. Usual occupation: Coal Mines Retired
11. Industry or business: Consolidation Coal Co.
FATHER 12. Name: Joseph Cesnick
13. Birthplace: Hungary
MOTHER 14. Maiden name: Kate Cavitz
15. Birthplace: Hungary
16. Informant: William Cesnick
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4, 1945 (month) (day) (year)
Cemetery or crematory: Belvedere Cemetery
Location: Midland
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. 5-4- 45 (Date rec'd by registrar) Mrs. Nancy M. Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 45 at 11 50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 19 45, to May 1 19 45
and that I last saw him alive on May 1 19 45

Immediate cause of death	DURATION
Myocardial Insufficiency	1 wk.
Due to Cardio-Vascular Renal disease	2 yrs.
with Acutes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.: ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. E. Gattens M.D. (M. D. or other)
Address: Frostburg, Md. Date signed: 5/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

1 04516

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Years

Hospital, Institution, or street address where death occurred:

Rt. 1, ~~LaVale~~

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 1 LaVale

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John W. Clark

3.(b) Social Security Number 212-18-1806

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Laura Clark

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): November 7 1872

8. AGE: Years	Months	Days	If less than one day
72	5	28	...hrs. ...min.

9. Birthplace: Barton, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Rose Hill Cemetery

FATHER 12. Name: John W. Clark

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Mary Hawkins

MOTHER 15. Birthplace: England

16. Informant: Miss Elizabeth Clark

Address: Rt, 1. Box 174, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 9 1945 (Date rec'd by registrar) Hunter R Dantz M.D. Registrar

MEDICAL CERTIFICATION about P.

20. DATE OF DEATH: May 4th., 19 45, at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Accidental Drowning	
Due to (Body recovered 5-6-45)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

...Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 5-4-45

Where did injury occur? near Cumberland. Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Braddock Run

Means of injury: acc. drowning Injured at work? no

23. SIGNATURE: Pierce H. Boyer M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 5-6-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

04517

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Sylvan Retreat
How long in hospital or institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Union St
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Robert Coleman

3.(b) Social Security Number 216-18-1925

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1879

8. AGE: Years 65 | Months 5 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Lonaconing, Md (Town, county, and state)
10. Usual occupation Orchard work
11. Industry or business Farm, Md
12. FATHER Name William Coleman
13. FATHER Birthplace Moscow, Md
14. MOTHER Maiden name Martha Dawson
15. MOTHER Birthplace Rawlings, Md
16. Informant Mrs Etta Savage
Address Lonaconing, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 45 (month) (day) (year)
Cemetery or crematory St Mary's Cemetery
Location Lonaconing, Md
18. Funeral director M. Eichhorn
Address Lonaconing Md
19. May 21 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20-45, at 4:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-12-44, to 5-20-45
and that I last saw him alive on 5-19-45

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	?
Due to	
Due to	
Other conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rev. F. Williams M. D. or other
Address Cumberland Date signed 5-24-45

VS A 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. WILLIAMS

T D4518

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Hampshire
City or town: Paw Paw
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mr. Floyd L. Crouse

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1907

8. AGE: Years	Months	Days	If less than one day
37	9	1	hrs. min.

8. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business

FATHER
12. Name: Mr. Howard L. Crouse
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Minnie McIntyre
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13, 1945 (month) (day) (year)
Cemetery or crematory: Maryland
Location: Maryland
18. Funeral director: [illegible]
Address: Capon Bridge W. Va.

19. May 11, 1945 (Date rec'd by registrar) Walter L. Hauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1945, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-7-45, 1945, to 5-10-45, 1945 and that I last saw h... alive on 5-10-45, 1945

Immediate cause of death: Cerebral Thrombosis — DURATION: From 5-7-45

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 5-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Outside City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

04519

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: Route 1. LaVale

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1. LaVale

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Adam Cupler

3.(b) Social Security Number: 220-07-6146

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie Meldrum Cupler

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1866

8. AGE: Years	Months	Days	If less than one day
79	4	11	..... hrs. ..... min.

9. Birthplace: Mahaffey, Penna. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Accountant

FATHER

12. Name: Perry C. Cupler

13. Birthplace: Mahaffey, Penna.

MOTHER

14. Maiden name: Mary E. Moffett

15. Birthplace: Westminister, Md.

16. Informant: Mrs. Bessie Cupler

Address: Route 1. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Bradford, Penna.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. May 16, 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15, 1945, at 4:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1945, to May 15, 1945 and that I last saw him alive on May 15, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	one week
Due to arterial hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elizabeth G. Briggs M.D. M. D. or other

Address Corp Md. Date signed 5/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Dorie H.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04520

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, Institution, or street address where death occurred:

619 N. Mechanic St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 N. Mechanic St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Annie Cecelia Dailey

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife John Henry Dailey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 17, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	26	..... hrs. ..... min.

9. Birthplace Frostburg, Allegany, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Thomas Hewitt

13. Birthplace Frostburg Md

MOTHER 14. Maiden name Margaret Firlie

15. Birthplace Frostburg, Md

16. Informant Mrs. Irene Long

Address 619 N. Mechanic St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16 1945 (month) (day) (year)

Cemetery or crematory St. Patrick's Cemetery

Location Cumberland, Md.

18. Funeral director John F. Hafer

Address Cumberland, Md.

19. May 16, 19 45 (Date rec'd by registrar) Winters R. Hartz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1945, at 5:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11, 1945 to May 13, 1945

and that I last saw her alive on May 13, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	5 hrs
Due to	
Due to Thrombosis	2 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Winters R. Hartz M. D. or other

Address Cumberland Md Date signed May 16 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

04521

Reg. Dist. No. 4

65

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, Institution, or street address where death occurred:

321 Averett Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany.

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 Averett Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Effie Jane DeVore

3.(b) Social Security Number 219-14-6948

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1887

8. AGE: Years	Months	Days	If less than one day
57	10	12	hrs. min.

9. Birthplace Hyndman, Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Kelly Springfield Tire Co.

FATHER 12. Name John W. DeVore

13. Birthplace Bedford County, Pa

MOTHER 14. Maiden name Susanna Emerick

15. Birthplace Somerset County, Pa.

16. Informant Mrs. Reynard Wiantzing

Address 321 Averett Ave - Cumb. Md

17. Burial Date thereof May 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. May 5, 1945 Walter K. Trenty, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-20 1945 to 5-3 1945 and that I last saw h. alive on 5-3 1945

Immediate cause of death	DURATION
Carcinoma of thyroid	6 mos.
Carcinomatosis	
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations Carcinoma of thyroid Date of op. 3-16-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Jones M.D.
M.D. or other

Address Medical Bldg Date signed 5.4.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-a

CERTIFICATE OF DEATH

04522

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Dunbar Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillian Irene Martin Dillon

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Paul Martin Dillon
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 10 1889

8. AGE:	Years	Months	Days	If less than one day
	55	8	17	..... hrs. ..... min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: House Wife.
11. Industry or business

FATHER
12. Name: Samuel Y. Buckman
13. Birthplace: England

MOTHER
14. Maiden name: Susan Stine
15. Birthplace: Kentucky

16. Informant: Paul Martin Dillon
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May (month) 30 (day) 1945 (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. May 28, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 19 45 at 12 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 45 to May 27 19 45 and that I last saw h.. alive on May 27 19 45

Immediate cause of death	DURATION
coronary occlusion	17 days
Due to: Cardiovascular syphilis	years
Due to:	
Other conditions: Tabes dorsalis	years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Brown, M.D. M. D. or other
Address: Town, Md. Date signed 5/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04523

Reg. Diat. No. 6

1. PLACE OF DEATH

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, institution, or street address where death occurred: 137 Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Beryl

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Blaine Duckworth

3.(b) Social Security Number 236-03-3805

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Pauline Stump Duckworth

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): March 6, 1888

8. AGE: Years 57 Months 1 Days 25 If less than one day ..... hrs. ..... min.

9. Birthplace: Elk Garden W. Va. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Coal mine

FATHER 12. Name: Manuel Duckworth

FATHER 13. Birthplace: Westernport Md.

MOTHER 14. Maiden name: Martha Smith

MOTHER 15. Birthplace: Springfield W. Va.

16. Informant: Mrs. Pauline Duckworth

Address: Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3 1945 (month) (day) (year)

Cemetery or crematory: Tichnell Cem.

Location: 7 Mi West of Bloomington Md

18. Funeral director: Ellsworth S. Beal

Address: Westernport Md.

19. May 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1945 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to May 1st 1945

and that I last saw him alive on Apr 30 1945

Immediate cause of death	DURATION
endocarditis,	6mo
Due to: Rheumatic fever,	2yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Piedmont W. Va. Date signed 5/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

04524

Reg. Diat. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 Furnace Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Iona May Yost Duckworth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Duckworth
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): May 21, 1873

8. AGE: Years: 70 Months: 8 Days: 7 If less than one day: hrs. min.

9. Birthplace: Bekin, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home

FATHER
12. Name: Joseph Yost
13. Birthplace: Eckhart, Md

MOTHER
14. Maiden name: Emiline Shallenberger
15. Birthplace: West Newton, Pa

16. Informant: Mrs. James Staup
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 30, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing Md.

19. May 30- 1945 (Date rec'd by registrar) Dr. E. Dan Foy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1945, to May 26 1945 and that I last saw h.. alive on May 26 1945

Immediate cause of death: Coronary Occlusion	DURATION
Due to:	
Due to:	
Other conditions: Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: May 30 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

Reg. Dist. No. 04525 4

1. PLACE OF DEATH:
County: Allegheny
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 hours
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West County: Preston
City or town: Terra Alta
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: - - - - -

3. (a) FULL NAME
Alice Rosetta Ashby Dumire

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: ## Alex Dumire
Deceased 6.(c) If alive, give age: - - - - years

7. Birth date of deceased (mo., day, yr.): June 20, 1895.

8. AGE: Years	Months	Days	If less than one day
49	10	25	....hrs. ....min.

9. Birthplace: Oakland, Garrett, Maryland
(Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business: Restaurant

FATHER
12. Name: Eusebius Ashby
13. Birthplace: Oakland, Md.

MOTHER
14. Maiden name: Rebecca Strawser
15. Birthplace: Cranesville, W. Va.

16. Informant: Mrs. Mae Titchenell
Address: Terra Alta, W.Va.

17. Removal and Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1945 (month) (day) (year)
Cemetery or crematory: #### Ashby, near Underwood, W.
Location: near Underwood, W.Va.

18. Funeral director: A. P. Fike
Address: Terra Alta, W. Va.

19. May 15, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: May 15, 1945. 19.... at 7:52 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 14 19 45 to May 15 19 45
and that I last saw h.. alive on May 14 19 45

Immediate cause of death: Cerebral Hemorrhage — DURATION: 12 hrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles E. Demut M.D.
M. D. or other
Address: Terra Alta, W.Va. Date signed: 5-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. GRACIE Brove

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04526

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 117 BLAUL AVE., (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JOYN DYCHE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife LAVINA LEWIS

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 24, 1874

8. AGE: Years 70 | Months 6 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace W.VA. Magnolia (Town, county, and state)

10. Usual occupation Retired

11. Industry or business City Policeman

FATHER 12. Name GEORGE DYCHE

FATHER 13. Birthplace West Virginia

MOTHER 14. Maiden name CINDY ASHKETTLE

MOTHER 15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc

Address Cumberland, Md.

19. May 26, 1945 (Date rec'd by registrar) Wirtes L. Hantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 26 1945, at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11, 1945 to May 26, 1945 and that I last saw h... alive on May 25 1945

Immediate cause of death	DURATION
Carcinoma of Pancreas	1 yr.
Due to	
Due to	
Other conditions Generalized Cancer & Cachexia (Include pregnancy within 3 months of death)	14 days

Major findings of operations Exploratory Date of op. 5-11-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. R. Crone M.D. M. D. or other

Address Medical Bldg Date signed 5-29-45

(M) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

04527

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 yrs

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 227 Arch St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James H. Eckshaw

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ella Brennan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 1864

8. AGE:

Years	Months	Days	If less than one day
80	6	—	..... hrs. ..... min.

9. Birthplace Ind.

(Town, county, and state)

10. Usual occupation Laborer.—

11. Industry or business City employee.

FATHER 12. Name Thomas Eckshaw

13. Birthplace Ind.

MOTHER 14. Maiden name Unknown

15. Birthplace Ind.

16. Informant Mrs Boyd T Bohrer.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24 '45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Sons.

Address Cumberland

19. May 24, 1945 (Date rec'd by registrar) Walter R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1945, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1945, to May 21 1945 and that I last saw h.... alive on May 21 1945

Immediate cause of death Cerebral Hemorrhage

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

DURATION
3 days

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. T. Johnson Jr. M.D. M. D. or other

Address Cumberland Md. Date signed 5-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-1)

CERTIFICATE OF DEATH

04528

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 yrs.

Hospital, Institution, or street address where death occurred:
714 Elm St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 Elm St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Elizabeth B Fields

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Fields

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 18 1863

8. AGE:

Years	Months	Days	If less than one day
81	9	16	..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER
12. Name: John Cope
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Howard Fields

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7 '45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. May 7 19 45 (Date rec'd by registrar) Walter L Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1944 to May 4 1945

and that I last saw h[illegible] alive on May 4 1945

Immediate cause of death: Cardio Vascular Disease — DURATION: 4

Due to:

Due to: Arterio Sclerosis — DURATION: 8 yrs

Other conditions:

(Includo pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M E B Owens M. D. or other

Address: [illegible] Date signed: 5-46-45

Mr. & Mrs. E. B. Owens.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

T 04529

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Maple St
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Charles Everett Frankfort

3. (b) Social Security Number: 214-07-2807

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

B.(b) Name of husband or wife: Alma Marie Frankfort

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): March 19, 1899

8. AGE: Years	Months	Days	If less than one day
46	1	19	..... hrs. ..... min.

9. Birthplace: Eversoy, West Moreland, Pa.
(Town, county, and state)

10. Usual occupation: Pressman

11. Industry or business: Celanese Corp. of America.

FATHER 12. Name: John W. Frankfort

FATHER 13. Birthplace: Ursina, Pa.

MOTHER 14. Maiden name: Emma H. Bloom

MOTHER 15. Birthplace: Broad Ford, Pa.

16. Informant: Mrs. Alma M. Frankfort

Address: 104 Maple St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John Tobin

Address: Cumberland, Md.

19. May 9, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

Dr. Enroll.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: May 8th., 1945, at 10.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Accidental burning	
Due to (Exploding acetone fumes)	19 hrs.
Due to Extensive second degree burns	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation ..... Date of op. .....

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5-7-45

Where did injury occur? Creseptown, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Celanese Corp.

Means of injury: igniting fumes Injured at work? yes

23. SIGNATURE: Pierce H. Bruce M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 5-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04530

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
615 Fairview Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 615 Fairview Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Mary Gellner

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Joseph Gellner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 5 1861

8. AGE: Years	Months	Days	If less than one day
83	11	11	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home
FATHER 12. Name: Justus Grabenstein
13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret Munday
15. Birthplace: Germany
16. Informant: Mrs Raymond E. Graim
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18 1945 (month) (day) (year)
Cemetery or crematory: St P & P Cem.
Location: Cumberland, Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.
19. May 18 1945 (Date rec'd by registrar) Hunter & Frantz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1945, at 12:20 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1945 to May 15 1945 and that I last saw h.. alive on March 15 1945
Immediate cause of death: Cancer of the uterus — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Group M.D
M. D. or other
Address: Coup Date signed: 5/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

74531

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred: 401 Columbia St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 401 Columbia St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Margaret Grabenstein
3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of husband or wife: Joseph H. Grabenstein
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov 10 1869
8. AGE: Years 75 | Months 6 | Days 8 | If less than one day ..... hrs. ..... min.
9. Birthplace: Myersdale Penna.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home

MOTHER FATHER
12. Name: John Stacer
13. Birthplace: Cumberland Md.

MOTHER
14. Maiden name: Mary Ann Breig
15. Birthplace: Salisbury Pa.

16. Informant: Justus Grabenstein
Address: Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21 1945 (month) (day) (year)
Cemetery or crematory: St. Peter & Paul's
Location: Cumberland Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland Md.
19. May 19 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1945 at 8:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1945, to May 18 1945 and that I last saw h[illegible] alive on May 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arterio sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. Weber M. D. or other
Address 122 Bedford St Date signed 5/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (446)

CERTIFICATE OF DEATH

T 04532

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

111 Mass. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 111 Mass. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Vernon Elwood Gray

3. (b) Social Security Number: Unable to Locate

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Gray

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1903

8. AGE: Years: 41 | Months: 7 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Barrellville, Md. (Town, county, and state)

10. Usual occupation: Brick Yard

11. Industry or business: Mt. Savage Brick Works

FATHER — 12. Name: Edward Gray

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Bessie Connor

15. Birthplace: Maryland

16. Informant: Mrs. Helen Gray

Address: 111 Mass. Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9, 1945 (month) (day) (year)

Cemetery or crematory: HillCrest Cemetery

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. May 9 1945 (Date rec'd by registrar) Walter R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1945, at 1 OP M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1945, to May 6 1945

and that I last saw him alive on May 6 1945

Immediate cause of death	DURATION
Tb Enterocolitis	6 mos.
Secondary	
Due to Pleurisy Chronic Disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. S. Adams M.D. M. D. or other

Address: 133 Va ave Date signed: 5/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

04533

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: 32 Hunstead St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 32 Hunstead St (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Ewell Harrison

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude Brinkman

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 14 1883

8. AGE:

Years	Months	Days	If less than one day
61	10	22	____ hrs. ____ min.

9. Birthplace: Keyser W. Va. (Town, county, and state)

10. Usual occupation: Employee B. & O. Ry.

11. Industry or business: Retired 20 yrs

FATHER

12. Name: Floyd Harrison

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Lovie Linsdon

15. Birthplace: Missouri

16. Informant: Gertrude B Harrison

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8 45 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. May 8, 1945 (Date rec'd by registrar) Victor L Routh M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1945, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1944, to May 6 1945 and that I last saw him alive on May 6 1945

Immediate cause of death	DURATION
Organic Heart Disease	20 yrs
Due to: Chronic Nephritis	20 yrs
Due to: Arteriosclerosis	20 yrs
Other conditions: Dropsy	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Thos A Harrison M. D. or other

Address: Cumberland Md Date signed: 5/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

4534

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred: 322 Frederick St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 322 Frederick St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Wm Swepston Heath

3. (b) Social Security Number: 219-03-8481

4. Sex: Male
5. Color or race: Black
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Charlotte Wilson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 17, 1886
8. AGE: Years: 59 Months: 4 Days: 12 If less than one day ..... hrs. ..... min.
9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: Fayer High School
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: Mrs Florietta Gales
Address: 927 Glenwood St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland Md.
18. Funeral director: John J Hafer
Address: Cumberland Md.
19. May 31, 1945 (Date rec'd by registrar) Winter L. Heath M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945 at 1:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 29 1945 and that I last saw h. alive on May 28 1945

Immediate cause of death	DURATION
Cancer Urinary Bladder	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. F. Trevaskis M.D.
Address: Cumberland, Md. M. D. or other
Date signed: May 30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

1 04535

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. FORT CUMBERLAND HOTEL
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MR. JOHN HOWE

3. (b) Social Security Number: 705-05-5174

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

B.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 24, 1877

8. AGE: Years 68 | Months 1 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace: PENNA. (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business: B. & O. R. R.

FATHER
12. Name: MARTIN HOWE
13. Birthplace: England

MOTHER
14. Maiden name: MARY Cunningham
15. Birthplace: Ireland

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9, 1945 (month) (day) (year)
Cemetery or crematory: St. Josephs Cem.
Location: Connellsville, Pa.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. May 7 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-5-1945, at 9:50 P.M.

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from 4-28-1945, to 5-5-1945
and that I last saw him alive on 5-4-1945

Immediate cause of death	DURATION
Diabetes Mellitus	?
Due to: Cardio Vascular Renal disease	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other
Address: Cumberland Date signed: 5-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124E)

CERTIFICATE OF DEATH

04536

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50. Years

Hospital, institution, or street address where death occurred:
21. Fifth Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: C umberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21. Fifth Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James A. Hunt

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hazel Hunt

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): December 13, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	12	...hrs. ...min.

9. Birthplace: Waynesboro, Virginia
(Town, county, and state)

10. Usual occupation: Engeneer - Retired

11. Industry or business: Baltimore & Ohio Railroad

FATHER
12. Name: Samuel Hunt
13. Birthplace: Huntersville Alabama

MOTHER
14. Maiden name: Fannie Ellison
15. Birthplace: Waynesboror, Virginia

18. Informant: Mrs. James A. Hunt
Address: 21. Fifth St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1945 (month) (day) (year)

Cemetery or crematory: Terra Alta Cemetery

Location: Terra Alta, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 26, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 15 1945 to May 25 1945

and that I last saw h alive on May 25 1945

Immediate cause of death: Cirrhosis of Liver

	DURATION
Due to:	2yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. R. Clemens M.D.
M. D. or other

Address: B'burg Date signed: 5/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

CERTIFICATE OF DEATH

04537

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
890 Sperry Terrace.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany.
City or town 890 Sperry Terrace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cumberland.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Hollie M. Iser.

3. (b) Social Security Number 217-10-1027.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Frances Moats Iser.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July-4-1911

8. AGE:	Years	Months	Days	If less than one day
	33	10	7.	...hrs. ...min.

9. Birthplace Augusta - West-Va.
(Town, county, and state)
10. Usual occupation TRUCK Driver.
11. Industry or business
FATHER 12. Name Isaac Iser.
13. Birthplace West-Va.
MOTHER 14. Maiden name Hattie Iser. Harrison
15. Birthplace West-Va.
16. Informant Frances Iser.
Address Cumberland, Md.
17. Burial Date thereof 5/20/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenfield W. Va.
Location Greenfield W. Va.
18. Funeral director Tobin Stein Inc.
Address Cumberland Md.
19. 5/19/45 19.... Winter R. Trantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14 1945, to May 17 1945 and that I last saw h... alive on May 8 1945

Immediate cause of death	DURATION
congestive heart failure	2 weeks
Due to chronic emphysema	several years
Due to bronchial asthma	several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. M. Iser M.D.
M. D. or other
Address Long Meadow Date signed 5-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Reynolds

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 04538

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
R.D.#3 Bedford Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.#3 Bedford Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Daniel Jay

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1931

8. AGE: Years	Months	Days	If less than one day
14	3	17	..... hrs. ..... min.

9. Birthplace: Bedofrd Co. Penna.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: Floyd Jay
13. Birthplace: Bedford Co., Penna.

MOTHER
14. Maiden name: Joanna Miller
15. Birthplace: Bedford Co. Penna.

16. Informant: Mr. Floyd Jay
Address: R.D.#3 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Union Cemetery
Location: Mt. Union, Penna.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. May 21 1945 (Date rec'd by registrar) Wm. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 15 1945, to May 19 1945
and that I last saw h... alive on May 18 1945

Immediate cause of death	DURATION
Acute Endocarditis	3 Mos
Acute Myocarditis	3 Mos
Due to: Rheumatic Fever	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. L. Grasonelli M. D. or other
Address: Cumberland Md. Date signed: 5/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

04539

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 45 Bond St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 45 Bond St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Laura Ellen Johnston

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel A Johnston

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 17 1881

8. AGE:

Years	Months	Days	If less than one day
63	10	27	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: William R Varnadale

13. Birthplace: Md

MOTHER

14. Maiden name: Anna Yost

15. Birthplace: Unknown

16. Informant: Mrs Edgar Merritt

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem

Location: Cumberland Md

18. Funeral director: Louis Allen Inc

Address: Cumberland Md

19. May 15 1945 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 15 1945 to May 14 1945

and that I last saw her alive on May 14 1945

Immediate cause of death	DURATION
Carcinoma Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Colon

Date of op. March 20 1945

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W E Bruns M.D. M. D. or other

Address: 132 Va Ave Date signed: 5/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

64540

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1320 Virginia Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Alleg
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1320 Va Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Margaret Kayle

3.(b) Social Security Number None

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Divorced
6.(b) Name of husband or wife Unknown
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) — Unknown

8. AGE: Years 87 Months — Days — If less than one day ... hrs. ... min.

9. Birthplace W Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Adam Kayle
13. Birthplace W Va

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Mrs Sidna Mayer
Address Cumberland Md

17. Removal Date thereof May 28 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Elkins Cem
Location Elkins W.Va.

18. Funeral director Louis Stein Inc
Address Cumberland Md

19. May 28, 1945 Winter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/23/45 19... to 5/27/45 19...
and that I last saw her alive on 5/27/45 19...

	DURATION
Immediate cause of death Pulmonary Hypostasis	4 da
Due to Senility	Unk
Due to Cerebral Sclerosis	Unk
Other conditions Frac R. Clavicle fell 5/20/45	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

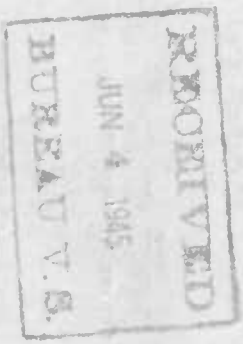
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? —
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Matthews M. D. or other
Address 161 S. Centre St Date signed 5/28/45

215

I must have this duplicate this morning

Stein



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

04541

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Frankelin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Mo. 24 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Franklin

(If outside city or town limits, write RURAL and give nearest town)

Street No. near Westernport

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Franklin Kellers.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 15, 1945

8. AGE: Years	Months	Days	If less than one day
	1	24	..... hrs. ..... min.

8. Birthplace: Franklin Allegany - Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Wilson E. Kellers

13. Birthplace: Westernport, Md.

MOTHER — 14. Maiden name: Ethel Harold

15. Birthplace: Martinsburg, W. Va

16. Informant: Wilson Kellers

Address: Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 1945 (month) (day) (year)

Cemetery or crematory: Private

Location: Westernport Md.

18. Funeral director: E. Lawrence S. Boal

Address: Westernport Md

19. May 10 1945 (Date rec'd by registrar) C. J. Faulkenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945 at 7.50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1945, to May 9, 1945, and that I last saw him alive on May 9, 1945.

Immediate cause of death	DURATION
acute myocardial failure	10 mins
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thomas Reese. M.D. M. D. or other

Address: Western Port, Md. Date signed 5-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

64542

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
57 Spring St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 57 Spring St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nannie McCulloh Kyle

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife David Kyle
6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) February 4, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	1	hrs. min.

9. Birthplace Frostburg Allegany City, Md.
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business home
FATHER 12. Name John R. Davis
13. Birthplace Maryland
MOTHER 14. Maiden name Mary A. House
15. Birthplace Maryland
16. Informant David Kyle
Address Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9-1945 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg Md.
18. Funeral director J. J. Durst
Address Frostburg Md.
19. 5-9 (Date rec'd by registrar) 1945 Mrs. Nancy L. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1945, to May 6 1945
and that I last saw her alive on May 6 1945

	DURATION
Immediate cause of death Cerebral hemorrhage	12 hrs.
Due to Hypertension; heart disease	6 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. E. Gatten, M. D. (M. D. or other)
Address Frostburg, Md. Date signed 5/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Coroner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

04544

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: rural near Danville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: rural near Danville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ruth Lancaster

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Benj. Walter Lancaste

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1873

8. AGE: Years	Months	Days	If less than one day
72	2	28	hrs. min.

9. Birthplace: Lawson, Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Waxler

FATHER — 13. Birthplace: Mineral Co. W.Va.

MOTHER — 14. Maiden name: Elizabeth Robinson

MOTHER — 15. Birthplace: Allegany Co. Md.

16. Informant: Mrs. Norma Gordon

Address: R#3 Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13, 1945 (month) (day) (year)

Cemetery or crematory: Waxler

Location: Danville, Md.

18. Funeral director: N.L. Rogers Funeral Directors

Address: Keyser, W.Va.

19. May 13 19 45 A. Gaynor Baer Md

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 19 45 at 12.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 41 to May 10 19 45

and that I last saw her alive on May 9 19 45

Immediate cause of death	DURATION
Acute dilatation of heart	sudden
Due to: Chronic myocarditis	3 yrs.
Due to: General arteriosclerosis	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E.A. Carrier, M.D. M. D. or other

Address: Keyser W. Va. Date signed: 5/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

T 04545

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs.

Hospital, institution or street address where death occurred:

57 Cumberland Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 57 Cumberland Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Woll Lappo

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John Lappo

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 6th. 1883

8. AGE:

Years	Months	Days	If less than one day
62	2	14	..... hrs. ..... min.

9. Birthplace Frostburg, Allegany, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Herman Woll

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Elizabeth Lappo

15. Birthplace Pennsylvania

16. Informant John Lappo

Address 57 Cemetery Rd. Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23-1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jas. H. Baker

Address Frostburg, Md.

1945-22 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945, to May 20 1945, and that I last saw her alive on May 10 1945.

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm C Lane Jr MD M. D. or other

Address Frostburg Md Date signed 5-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

T 04546

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Franklin, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Franklin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Lambert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Katherine Barnes Lambert 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1868

8. AGE: Years 77 | Months 4 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal mine

FATHER — 12. Name: Henry Lambert

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Margaret Schmitz

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Martha D. Allbritten

Address: Franklin Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) May (day) 19 (yr) 1945

Cemetery or crematory: Pilas Cem.

Location: Westernport, Md.

18. Funeral director: Mrs. Kay Boal Berry

Address: Westernport Md.

19. (Date rec'd by registrar) May 18 1945 Registrar: Clayton Baker M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1945, at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1945, to May 17 1945 and that I last saw him alive on May 17 1945

Immediate cause of death	DURATION
Bronchial pneumonia	1 day
Due to	
Due to	
Other conditions: Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Norman Reeves M.D.
M. D. or other

Address: Westernport Md. Date signed: 5.18.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Diat. No. 04545 9

1. PLACE OF DEATH:

County: Allegany

City or town: ~~[illegible]~~ Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 yrs.

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 4 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Borden Mines, Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Gertie Mae Leasure

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Isaac Leasure

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 29th, 1892

8. AGE: Years 53 | Months 3 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Solger Nagle

FATHER 13. Birthplace: Borden Mines, Md.

MOTHER 14. Maiden name: Elizabeth Taylor

MOTHER 15. Birthplace: Pennsylvania

18. Informant: Mrs. Edward Elliott

Address: Eckhart Mines, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 (month) (day) 1945 (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Daniel Walker

Address: Frostburg, Md.

19. 5-29 (Date rec'd by registrar) 1945 Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1945 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 15 1945, to May 28 1945, and that I last saw h[illegible] alive on May 28 1945

Immediate cause of death	DURATION
General Carcinomatosis	2 mo.
Due to: Carcinoma of Left Breast	6 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Left Breast Date of op. Apr. 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. M. Lane M.D.
M. D. or other

Address: Frostburg, Md. Date signed May 29 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160C)

CERTIFICATE OF DEATH

T 04548

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Alleg.

City or town: Near Cumberland Limits Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #3, Bedford Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: James Llewellyn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 13 1945

8. AGE: Years | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Allegany Hosp Cumberland

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: John Wesley Llewellyn

13. Birthplace: Md

MOTHER

14. Maiden name: Mary M Grabenstein

15. Birthplace: Md

16. Informant: John W Llewellyn

Address: RFD 3 City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 14 1945 (month) (day) (year)

Cemetery or crematory: St Pat Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. May 14 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945; at 9:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1945 to May 13 1945 and that I last saw him alive on May 13 1945

Immediate cause of death	DURATION
Birth Pneumonia	2 hrs
Due to: Heart Failure	
Due to:	
Other conditions: Edentulous	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Md Date signed: May 14 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

04549

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, Institution, or street address where death occurred: 753 Washington St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 753 Washington St (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary G. Loar

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John H. Loar
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 16, 1882
8. AGE: Years: 62 Months: 10 Days: 12 If less than one day: hrs. min.
9. Birthplace: Barton Allegany, Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home
FATHER 12. Name: Alexander Greenham
13. Birthplace: Unknown
MOTHER 14. Maiden name: Jean Thomson
15. Birthplace: Scotland
16. Informant: Miss Margaret Loar
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: D. Eichhorn
Address: Lonaconing, Md.
19. May 31, 1945 (Date rec'd by registrar) Walter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-28-1945, at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 1944, to 5-28-1945 and that I last saw h... alive on 5-28-1945

	DURATION
Immediate cause of death: Carcinoma	6 mos
Due to: Carcinoma of Left breast	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Left breast Date of op. 6 yrs. ago.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 5-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-b)

04543

CERTIFICATE OF DEATH

Reg. Diat. No. 7

1. PLACE OF DEATH:

County: Allegany

City or town: Baston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Alleg

City or town: Baston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Agnes Mc Cormick Logsdon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Daniel Logsdon

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29, 1867

8. AGE: Years 77 | Months 10 | Days — | If less than one day: hrs. min.

9. Birthplace: Baston, Alleg, Md.

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER — 12. Name: Joseph Mc Cormick

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Jane Matthison

15. Birthplace: Scotland

16. Informant: Robert Mc Cormick

Address: Baston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1, 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Mason, Md.

18. Fuoeral director: Mrs. Fay Boal Berry

Address: Westernport, Md.

19. May 30 1945 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29, 1945 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to May 29 1945 and that I last saw h-r alive on May 24 1945

Immediate cause of death	DURATION
Chronic Myocarditis	4 mo.
Chronic nephritis	"
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Norman Reeves, M.D. M. D. or other

Address: Westernport Md Date signed 5-30-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Hawkins

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

04550

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State W. VA. County HAMPSHIRE
City or town LEVELS (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME MR. JAMES S. MALCOLM

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife LEE KAYLOR MALCOLM
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) APRIL 14, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	15	hrs. min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual occupation FARMER
11. Industry or business
12. Name of father MALCOLM, ROBERT
13. Birthplace of father W. VA.
14. Maiden name of mother MILLERY, MARTHA
15. Birthplace of mother W. VA.
16. Informant Mrs Lee Malcolm
Address Levels, W. Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1945 (month) (day) (year)
Cemetery or crematory Wesley Chapel
Location Point Rock
18. Funeral director A. H. McKee
Address Augusta W. Va.
19. June 1, 1945 (Date rec'd by registrar) Winter P. Hantz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 29, 1945, at 1:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1945 to May 29 1945 and that I last saw h[illegible] alive on May 29, 1945

Immediate cause of death	DURATION
Myocardial Collapse	
Due to Diabetes Mellitus	
Carcinoma Stomach	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Exploratory Surgery Carcinoma Stomach Date of operation
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other
Address Cumberland Md Date signed 5-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

04551

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yrs
Hospital, Institution, or street address where death occurred:
110 Bedford St
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 Bedford St
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Mary Malloy.

3.(b) Social Security Number None

4. Sex Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Ed. J. Malloy.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) about 1862

8. AGE: Years 83 | Months — | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace Aurora Ind.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home.

FATHER
12. Name James Carlin
13. Birthplace Ireland

MOTHER
14. Maiden name Winifred Vahey
15. Birthplace Ireland

16. Informant Mrs. George Weston
Address Cumberland.

17. Burial & Removal Date thereof May 22 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Olivet Cem.
Location Aliquippa, Beaver Co Pa.

18. Funeral director Louis Stein Inc.
Address Cumberland.

19. May 22 19 45 Winter P Beatty MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 45, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 19 44, to May 21 19 45
and that I last saw h[illegible] alive on May 19 19 45

Immediate cause of death chronic myocarditis — DURATION one year

Due to arteriosclerosis — several years

Due to —

Other conditions rheumatoid arthritis — several years

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE L. Weis M D
M. D. or other
Address Long Hill Date signed 5-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

T 04552

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs.
Hospital, institution, or street address where death occurred: 933 Gay St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 933 Gay St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Edward Malone

3.(b) Social Security Number 705-05-4604

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Malone (Cpthro)
6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Mar 21, 1902

8. AGE:

Years	Months	Days	If less than one day
43	1	25	...hrs. ...min.

9. Birthplace Cumberland Md (Town, county, and state)
10. Usual occupation Machinest
11. Industry or business Bolt & Forge
FATHER 12. Name Burr Malone
13. Birthplace Davis Run W.Va.
MOTHER 14. Maiden name Nettie Maiser
15. Birthplace Davis Run W.Va.
16. Informant Alvin Malone
Address Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1945 (month) (day) (year)
Cemetery or crematory Davis Run W.Va.
Location
18. Funeral director Louis Stein Inc
Address Cumberland Md
19. May 18 1945 (Date rec'd by registrar) Hunter R. Grant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1945 to May 16 1945
and that I last saw h... alive on May 14 1945
Immediate cause of death Coma

	DURATION
Due to Diabetes	3 days
Due to	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Blowers M.D.
M. D. or other
Address 133 Va Ave Date signed 5/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-B)

CERTIFICATE OF DEATH

04553

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Allegany
City or town: Corriganville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Corriganville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bernard E. Martin

3.(b) Social Security Number 214-05-5905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia N. Lapp
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): May 21, 1895

8. AGE:

Years	Months	Days	If less than one day
49	11	17	...hrs. ...min.

9. Birthplace: Cumberland, Md (Town, county, and state)
10. Usual occupation: Line-Keeper at Koppers Co.
11. Industry or business
FATHER 12. Name: Frank Martin
13. Birthplace: Md
MOTHER 14. Maiden name: Hannah A Humberston
15. Birthplace: Frostburg - Md.
16. Interment: Mrs. Bernard E. Martin
Address: Corriganville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1945 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Cumberland, Md
18. Funeral director: W. H. Zeigler
Address: Hyndman, Pa.
19. May 10 1945 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: May 8th., 1945 at 12:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Accidental Carbon Monoxide Poisoning.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 5-8-45
Where did injury occur? Corriganville, Allegany, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): garage, at home
Injured at work? no
Means of injury: exhaust from automobile engine

23. SIGNATURE: Bruce H. Larson, M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 5-8-45
Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 04554 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 241 New Hampshire Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Michael T. Matthews

3. (b) Social Security Number: 705-09-9674

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 21 1877

8. AGE:

Years	Months	Days	If less than one day
67	7	14	hrs. min.

9. Birthplace: Cumberland Md
(Town, county, and state)
10. Usual occupation: Carman
11. Industry or business: Balto & Ohio R R
FATHER 12. Name: Michial Matthews
13. Birthplace: Ireland
MOTHER 14. Maiden name: Johanna Daughaney
15. Birthplace: Ireland
16. Informant: Mrs Frank Hewitt
Address: 241 New Hampshire ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 1945 (day) (year)
Cemetery or crematory: St Patrick's
Location: Cumberland
18. Funeral director: Jamison Stein & Son
Address: Cumberland Md
19. May 8, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th., 1945 at 5.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Phillips H. Bosley, M. D.
M. D. or other
Address: Cumberland, Maryland Date signed: 5-5-45

Deputy Medical Examiner - Allegany Co.

Dr. Tolson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-D)

CERTIFICATE OF DEATH

04556

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 29 Frost Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Mr. Frank A. Mattingly

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pearl Hafer
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): November 11, 1891

8. AGE: Years	Months	Days	If less than one day
~~54~~ 53	6	0	....hrs. ....min.

9. Birthplace: Maryland, Cresaptown (Town, county, and state)
10. Usual occupation: Funeral Director
11. Industry or business: Hafer's Funeral Home

FATHER
12. Name: Bernard Mattingly
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Elizabeth Ruhl
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md
18. Funeral director: [illegible]
Address: Cumberland, Md

19. May 13 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1945 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-4- 1945 to 5-11- 1945 and that I last saw him alive on 5-10- 1945

Immediate cause of death	DURATION
Chronic nephritis with hypertension	years?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: Cumberland, Md. Date signed 5-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Gilmore

04557

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Cert 1454

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:
The Dingle

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: The Dingle
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Addison Gilmore McElfish

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Adeline McElfish

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): July 8, 1871

8. AGE: Years	Months	Days	If less than one day
73	9	6	...hrs. ...min.

9. Birthplace: Murley's Branch, Allegany Co, Md
(Town, county, and state)

10. Usual occupation: Banker

11. Industry or business: Cumberland Saving Bank

FATHER
12. Name: Luther McElfish
13. Birthplace: Murley's Branch, Md,

MOTHER
14. Maiden name: Jennie Hinkle
15. Birthplace: Mt. Plesant, Md.

16. Informant: Mrs. Addison G. McElfish
Address: The Dingle, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 16, 1945 Winter R. Frantz, M.D. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1945, at 5-30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945, to May 14 1945 and that I last saw h... alive on May 14 1945

Immediate cause of death: Chronic Myocarditis — DURATION: 3 yr

Due to: Arteriosclerosis — 5 yr

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. E. Pearson M.D.

Address: 26 Decatur St Cumberland Md. M. D. or other

Date signed: 5/15/45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

T 04558

Reg. Dist. No. 4

Burial

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, Institution, or street address where death occurred: 804 Maplewood Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 Blair St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Julia Ann McGreevy

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife Owen P. McGreevy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 31, 1874

8. AGE:

Years	Months	Days	If less than one day
71	1	9	..... hrs. ..... min.

9. Birthplace Eckhart Mines Allegany Co. Md (Town, county, and State)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name George Kreitzburg

13. Birthplace Maryland

MOTHER 14. Maiden name Sarah Lyons

15. Birthplace Maryland

16. Informant Mrs Lawrence J. Matt.

Address 804 Maplewood Lane-Cumb

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12, 1945 (month) (day) (year)

Cemetery or crematory St Michaels Cemetery

Location Frostburg Md

18. Funeral director John F. Hafley

Address Cumberland Md.

19. May 12, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1945, at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1945, to May 10, 1945

and that I last saw her alive on May 8, 1945

Immediate cause of death	DURATION
Bronchial Asthma	10 yrs
Myocarditis	4 yrs
Arteriosclerosis	6 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Mary K. Lawrence M. D. or other

Address Cumberland Date signed 5/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04559

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Rural near Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 5

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward Garfield Mc Intosh

3.(b) Social Security Number: 705-05-8929

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Ada A. Hewitt

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): July 19, 1880

8. AGE:

Years	Months	Days	If less than one day
64.	10	8	hrs. ____ min.

9. Birthplace: Edinburg Shenandoah Co. Va. (Town, county, and state)

10. Usual occupation: Retired Conductor

11. Industry or business: B. & O. Railroad

FATHER

12. Name: James K. Mc Intosh

13. Birthplace: Unknown

MOTHER

14. Maiden name: Harriett Walters

15. Birthplace: Unknown

16. Informant: Mrs E. J. Mc Intosh

Address: R.F.D 5 Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 (month) (day) 1945 (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. May 28, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 19 45 at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 43 to May 27 19 45

and that I last saw h... alive on 5/27 19 45

Immediate cause of death: coronary occlusion — DURATION: years

Due to: arteriosclerosis — "

Due to: arterial hypertension — "

Due to: coronary sclerosis — "

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Bruce, M.D. M. D. or other

Address: Long, Md. Date signed: 5/29/45

DR. MURRAY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04560

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 216 SEYMOUR ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MR. RICHARD McINTOSH

3.(b) Social Security Number: 715-09-9889

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: CATHERINE MILLER
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): May 28, 1897

8. AGE:	Years	Months	Days	If less than one day
	48	0	0	hrs. min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)
10. Usual occupation: Machinists helper
11. Industry or business: B. and O. R.R. Co. Shops

MOTHER FATHER
12. Name: GEORGE McINTOSH
13. Birthplace: VIRGINIA

MOTHER
14. Maiden name: MARY COOK
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31, 1945 (month) (day) (year)
Cemetery or crematory: Zion Memorial Cemetery
Location: Cumberland Md.
18. Funeral director: John J. Hafer
Address: Cumberland Md

19. May 29 19 45 (Date rec'd by registrar) Winter L. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 28 19 45 at 4:00A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 19 45 to May 28 19 45 and that I last saw h alive on May 27 19 45

Immediate cause of death	DURATION
Acute dilatation of heart	one hour
Due to Lobar Pneumonia	
in Upper Middle Lobe Right Lung	8 days
Due to Influenza	3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Allen G. Krumm M.D. M. D. or other
Address: Cumberland Md Date signed May 28 45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04361

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 Yrs.
Hospital, institution, or street address where death occurred:
220 Grand Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 220 Grand Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Grace E. Milburn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James L. Milburn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	8	..... hrs. ..... min.

9. Birthplace: Paw Paw, W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John A. Malcolm
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Frances Hardy
15. Birthplace: W. Va.

16. Informant: Mr. Walter Milburn
Address: 400 York Place, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1, 1945 (month) (day) (year)
Cemetery or crematory: St. Patricks Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. May 31 1945 (Date rec'd by registrar) Hunter R. Crosby, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 18. 1945, to May 28. 1945 and that I last saw h.. alive on Mar. 15. 1945

Immediate cause of death	DURATION
Chronic Myocarditis	16 yrs.
Degeneration	Past
Due to	Heart
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. L. Williams M. D. or other
Address: Cumberland Date signed: 5.31.'45

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

F 04555

Reg. Diat. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anthony Natolly

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Josephine Natolly

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): April 4 - 1891

8. AGE: Years	Months	Days	If less than one day
54	1	23	hrs. min.

9. Birthplace: Sicily (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace

MOTHER 14. Maiden name: unknown

15. Birthplace

16. Informant: Carl Natolly

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30-1945 (month) (day) (year)

Cemetery or ~~crematory~~: methodist

Location: Mt. Savage, Md.

18. Funeral director: J. E. Dent

Address: Frostburg

19. 5/29/1945 (Date rec'd by registrar) Veronica M. Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1945 at 5:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-27-1945 to 5-27-1945 and that I last saw him alive on 5-27-1945

Immediate cause of death	DURATION
Myocarditis	
Mitral Regurgitation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William E. Manley M.D.

M. D. or other

Address: Mt Savage Md Date signed 5-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04562 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
821 Gephart Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 821 Gephart Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Henry Nevy

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Iasuni Nevy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1880

8. AGE: Years	Months	Days	If less than one day
64	11	26	hrs. min.

9. Birthplace: Bergotto D. Berecto Italy
(Town, county, and state)
10. Usual occupation: Partner
11. Industry or business: Cumberland Macaroni Co.

FATHER
12. Name: Anthony Nevy
13. Birthplace: Italy

MOTHER
14. Maiden name: Catherine Grassi
15. Birthplace: Italy

16. Informant: Mr. David Nevy
Address: 821 Gephart Dr. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Burial Park
Location: Cumberland, Md.

16. Funeral director: Charles L. George
Address: Cumberland, Md.

19. May 3 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1945, at 2:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-10 1944 to May 2 1945
and that I last saw h[illegible] alive on April 21 1945

Immediate cause of death	Cancer of the bronchus	DURATION one year
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: cancer of the left main bronchus Date of op. 12-20-44

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C Brin M.D. (M. D. or other)
Address: Lonaconing Md. Date signed 5-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04563

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Mexico Farms, Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Weeks

Hospital, institution, or street address where death occurred:
Route 4, Cumberland, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Part Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mexico Farms Rt. II 4
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Grace Glendora Often

3.(b) Social Security Number: 216-22-5899

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Henry Often

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): December 28, 1907

8. AGE:	Years	Months	Days	If less than one day
	37	4	4	...hrs. ...min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Grocery Store

FATHER
12. Name: James O. Jenkins
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ella M. Hite
15. Birthplace: Bedford Co., Pa.

16. Informant: Mrs. James O. Jenkins
Address: Rt. 4, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant Cemetery

Location: Route 2, Cumberland, Md

18. Funeral director: John F. Hafer

Address: Cumberland, Md

19. May 4, 1945 (Date rec'd by registrar) Winter R. Bantz, M.D. Registrar

Burial

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1945, at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11, 1945 to May 2, 1945 and that I last saw h... alive on Apr. 20, 1945

Immediate cause of death	DURATION
Carcinoma of Uterus	3 mos
Due to: Carcinomatosis	6 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Uterus

Date of op. Sept. 1943

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Alan F. Jones M. D. or other

Address: Cumberland Date signed: 6/3/45

Correct.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04564

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 20 Arch Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary E O'Neil

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Oneil
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16, 1860

8. AGE: Years	Months	Days	If less than one day
84	10	25	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Philip McDonald
13. Birthplace: md
MOTHER 14. Maiden name: Ellen Geyer
15. Birthplace: md
16. Informant: Mrs James Keech
Address: 405 Grand ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 14 1945 (month) (day) (year)
Cemetery or crematory: St Patrick
Location: Cumberland md
18. Funeral director: Geo's Stein Inc
Address: Cumberland Md
19. May 12 1945 (Date rec'd by registrar) Walter K Gantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-11 1945 at 7: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1945 to May 11, 1945
and that I last saw h alive on May 10. 1945

Immediate cause of death	DURATION
Arteriosclerosis	10 yrs
Myocarditis	5
Due to: Uraemia	1 day
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clay R. Jones M. D. or other
Address: Cumberland Date signed: 5/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

T 04565

Reg. Diat. No. 1

1. PLACE OF DEATH:
County: Allegheny
City or town: Rural Little Orleans
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, institution, or street address where death occurred:
Residence- Little Orleans Dist.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegheny
City or town: Rural Little Orleans
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Leticia Price

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George O. Price
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5 - 1870

8. AGE: Years	Months	Days	If less than one day
74	11	25	hrs. min.

9. Birthplace: Fulton County, Pa.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER 12. Name: Henry Lee
13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Charlotte Rice
15. Birthplace: Pennsylvania

16. Informant: Clarence L. Price
Address: Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1945 (month) (day) (year)
Cemetery or crematory: Piney Plains Cemetery
Location: Hancock R D Route 40 West

18. Funeral director: Snyder-Rowland Funeral Home
Address: Hancock, Maryland.

19. May 2 1945 (Date rec'd by registrar) T. T. Mann per M.E.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1945 10:00 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1945 to May 1 1945
and that I last saw her alive on April 29 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. A. Watson M.D
M. D. or other
Address: Little Orleans, Md. Date signed 5/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

04566 T

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Adam Edgar Pugh

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Sarah Ellen Risner

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Feb - 19 - 1871

8. AGE:

Years	Months	Days	If less than one day
74	2	15	...hrs. ...min.

9. Birthplace: Wolverhampton, England
(Town, county, and state)

10. Usual occupation: Retired Miner

11. Industry or business: Coal

FATHER
12. Name: Archibald E. Pugh
13. Birthplace: England

MOTHER
14. Maiden name: Ann Hill
15. Birthplace: England

18. Informant: Russell E. Pugh
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May - 7 - 1945 (month) (day) (year)
Cemetery or crematory: Allegany
Location: Frostburg

18. Funeral director: Jacob Kafer
Address: Frostburg, Md.

19. 6-5-45 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1945, at 6 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/10 1945, to 5/4 1945 and that I last saw him alive on 5/1 1945

Immediate cause of death	DURATION
Cardiovascular Renal Disease	1 yr
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: Hilda Jane Walters, M.D.
M. D. or other

Address: Frostburg Md Date signed 5/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

04567

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY MD.
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 Years
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 508 SHRIVER AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR WILLIAM T. RILEY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6.(b) Name of husband or wife Melba Miller Riley
6.(c) If alive, give age 30 years
7. Birth date of deceased (mo., day, yr.) MAY 9 1887

8. AGE: Years	Months	Days	If less than one day
58	0	3	...hrs. ...min.

9. Birthplace MARYLAND, ALLEGANY (Town, county, and state)
10. Usual occupation OPERATES DINGLE CLEANERS
11. Industry or business
FATHER 12. Name JOHN RILEY
13. Birthplace MD.
MOTHER 14. Maiden name KATIE STUMPH
15. Birthplace MD.
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.
17. Burial Date thereof 5/15/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md
18. Funeral director William H. Kicht
Address Cumberland, Md.
19. May 13, 1945 Winter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 12 1945, at 5:30 a.m.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 5-4-1945, to 5-12-1945
and that I last saw him alive on 5-11-1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	One Wk.
Due to Generalized Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. T. Williams M. D. or other
Address Cumberland Date signed 5-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

04568

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town OLDTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. GOLDIE M. ROBERTSON

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife CHESTER ROBERTSON
6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) MAY 1, 1901

8. AGE: Years	Months	Days	If less than one day
44	0	10	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER 12. Name NEWTON B. CARTER
13. Birthplace MARYLAND

MOTHER 14. Maiden name CLARA O'NEIL
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1945 (month) (day) (year)
Cemetery or crematory Old Town Cem.
Location Old Town, Md.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. May 14, 1945 (Date rec'd by registrar) Walter L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11, 1945 19 at 11:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 45, to May 11 19 45
and that I last saw ... alive on May 11 19 45

Immediate cause of death	DURATION
Acute Dilatation of Heart	
Due to Chronic Myocarditis	
Due to Cardiac	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. C. Andrews M. D. or other
Address Cumberland Date signed 6/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

04569

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Central Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clara Mae Ruppert

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Henry A. Ruppert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16 1884

8. AGE: Years	Months	Days	If less than one day
60	9	28	..... hrs. ..... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER

12. Name William Gardner

13. Birthplace Pa.

MOTHER

14. Maiden name Mary Fetters

15. Birthplace Pa.

16. Informant Henry A. Ruppert

Address 410 Central Ave. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18 1945 (month) (day) (year)

Cemetery or crematory St P & P Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. May 15 1945 Winter R. Frantz M.D. Registror

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th 1945, at 9:18 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec - 1943, to May 14 - 1945

and that I last saw h[illegible] alive on May 14 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	Since April 1945
Due to Carcinomatosis	
Due to Carcinoma of Breast	1943
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Operation Dec 1943 Removal Rt Breast Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. L. Owens M D

M. D. or other

Address Cumberland Md Date signed 5-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04570

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

Rear of 20 Potomac St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Jefferson

City or town Harpers Ferry

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Charlet Malinda Piper

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife George W. Piper

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1859

8. AGE: Years	Months	Days	If less than one day
86	4	28	..... hrs. ..... min.

9. Birthplace Columbus, Ohio.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home.

FATHER
12. Name Mansfield (James)
13. Birthplace Ohio

MOTHER
14. Maiden name Kirk
15. Birthplace Columbus, Ohio.

16. Informant Mrs D. F. Izett

Address Rear 20 Potomac St Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1945 (month) (day) (year)

Cemetery or crematory Davis Memorial Cemetery

Location Near Cumberland, Md

18. Funeral director John J. Hofer.

Address Cumberland, Md.

19. June 1, 1945 (Date rec'd by registrar) Winter K. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-2- 19 43 to 5-29 19 45 and that I last saw h... alive on 5-28 19 45

Immediate cause of death	DURATION
congestive heart failure	5 days
Due to chronic myocarditis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Frantz MD
M. D. or other

Address Long Mod Date signed 5-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40-C)

04571

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 6½ HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State Pennsylvania County Bedford

City or town Hyndman
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME (NEWBORN) PORTER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	NEWBORN

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 31, 1945

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 36 min.

9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name ELMER PORTER
13. Birthplace MD.

MOTHER
14. Maiden name HAZEL GARLOCK,
15. Birthplace PA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1945 (month) (day) (year)

Cemetery or crematory White Oak Cem.

Location White Oak, Penna.

18. Funeral director Louis Stein, Inc.

Address Cumberland, md.

19. May 31 1945 (Date rec'd by registrar) Winter R. Hantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 31 1945 to May 31 1945 and that I last saw h.(m) alive on 1945

Immediate cause of death Prematurity. — DURATION 6 hrs.

Due to Cesarean section — DURATION 6 hrs.

Due to Carcinoma of cervix in mother. — DURATION 6 hrs.

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE C. P. Hodges, M.D.

Address Cumberland, Md. — M. D. or other — Date signed 5/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

1 04572

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegheny County

City or town: near Cumberland, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks

Hospital, institution, or street address where death occurred: North Branch, R.F.D. #4

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Pennsylvania County: ~~Allegheny~~

City or town: Mercersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Paul Emory Robinson

3.(b) Social Security Number: 220-05-6740

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 1, 1916

8. AGE: Years 28 | Months 8 | Days 7 | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Labor on Section Hand

11. Industry or business: Rail Road

FATHER — 12. Name: Fred Lester Robinson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Alice May Smith

MOTHER — 15. Birthplace: Pa.

16. Informant: Fred Lester Robinson

Address: Mercersburg, Pa. R.F.D.#2

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12th. 1945 (month) (day) (year)

Cemetery or crematory: Dunkard Church

Location: Welsh Run Maryland

18. Funeral director: Edith V. Leaf

Address: #7 Church St. Williamsport, Md.

19. May 8 1945 (Date rec'd by registrar) Wintes R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8th., 1945, at about 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Prince H. Brown, M. D. M. D. or other

Address: Cumberland, Maryland Date signed: 5-8-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

REC...

MAY 15 1945

BUREAU V.S.

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

T 04573

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: HAMPSHIRE
City or town: GREEN SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) ✓
2.(a) If veteran, name war

3.(a) FULL NAME: REV. JAMES D. ROCKWELL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MARY NORA BIGGS
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): DEC. 6, 1885

8. AGE: Years: 59 | Months: 5 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual occupation: MINISTER

11. Industry or business

FATHER
12. Name: SCOTT ROCKWELL
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: FRANCES COURTNEY
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29, 1945 (month) (day) (year)
Cemetery or crematory: BETHAL CEMETERY
Location: SLEEPY CREEK, W.VA.

18. Funeral director: THRUSH'S FUNERAL HOME
Address: ROMNEY, W.VA.

19. May 29, 1945 (Date rec'd by registrar) Walter L. Davis, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 26, 1945, at 12:25A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945 to May 26, 1945
and that I last saw h[illegible] alive on May 26, 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	
Due to Post Hemorrhage	
Due to Carcinoma of Bowel	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. C. Enfield M. D. or other
Address: Cumberland Md. Date signed 5/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1376)

CERTIFICATE OF DEATH

04574 Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Morgan
City or town: Paw Paw
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs. Una Rush

3. (b) Social Security Number >

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albright Rush
6.(c) If alive, give age: 33 years
7. Birth date of deceased (mo., day, yr.): October 13 1907

8. AGE: Years	Months	Days	If less than one day
37	7	3	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation:
11. Industry or business: Keystone Tanning & Glue Co.
FATHER 12. Name: B. E. Miller
13. Birthplace: West Virginia
MOTHER 14. Maiden name: Ida Miller
15. Birthplace: West Virginia
16. Informant: Memorial Hospital
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/19/45 (month) (day) (year)
Cemetery or crematory: Salem Cemetery
Location: Slanesville, W. Va.
18. Funeral director: W. D. Parks
Address: Berkeley Springs, W. Va.
19. May 18 1945 (Date rec'd by registrar) Winter R Frantz MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 6:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945, to May 16 1945
and that I last saw her alive on May 14 1945

Cause	Duration
Immediate cause of death: Shock following	1 —
Due to: Laparotomy for repair	
Due to: of rupture of bladder	4 days

Other conditions: Patient denied any violence, and there were no external evidences of trauma. She had been drinking the night before admission. C.W.G.R.
(Include pregnancy within 3 months of death)

Major findings of operations: Laceration of bladder
Date of op. 5-16-45
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. M. Wilson MD — M. D. or other
Address: Cumberland, Md. Date signed 5-16-45

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

04575 Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 122 THOMAS STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SAMIKOS, ~~BABY BOY #2~~ John Royces

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 22, 1945

8. AGE: Years | Months | Days: 12 | If less than one day: hrs. min.

9. Birthplace MEMORIAL HOSPITAL CUMBERLAND, MD. (Town) (county) (state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name DANIS SAMIKOS
13. Birthplace GREECE

MOTHER 14. Maiden name MARGARET ENGLAND
15. Birthplace PENNA.

18. Informant Danis Samikos
Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5, 1945 (month) (day) (year)
Cemetery or crematory Meadtown Cemetery
Location Meadtown Pa.

18. Funeral director John J. Hafer
Address Cumberland, Md

19. May 5, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 3, 1945 10:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I last attended deceased from ~~April 20, 45~~ to May 3 1945 and that I last saw ~~him~~ alive on May 3 1945

Immediate cause of death	DURATION
Due to Prematurity	
Due to Diabetes Mellitus	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE W. P. Hodges, M.D.
Address Cumberland, Md M. D. or other
Date signed 5/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T 04580

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. COR. GRAND AVE. & SECOND ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. JOHN J. SCREEN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6.(b) Name of husband or wife JOSEPHINE THOMPSON 6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) AUGUST 17, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	26	...hrs. ...min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER — 12. Name JOSEPH SCREEN
13. Birthplace ENGLAND

MOTHER — 14. Maiden name JANET ROBERTSON
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1945 (month) (day) (year)

Cemetery or crematory Oak Hill Cem

Location Lonaconing, Md.

18. Funeral director Mc Eichhorn's

Address Lonaconing, Md.

19. May 15, 1945 (Date rec'd by registrar) Winter L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 19 45, to May 13, 19 45, and that I last saw him alive on May 13, 19 45

Immediate cause of death	DURATION
General peritonitis	
Due to Ruptured Appendix	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Ruptured Appendix General peritonitis Date of op. May 10-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Clapsaddle M. D. or other

Address Cumberland Date signed 6/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64579

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 Glenmore Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Adelaide Seefeld

3.(b) Social Security Number: 722-05-5215

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert Seefeld
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): October 13 1896

8. AGE: Years	Months	Days	If less than one day
48	6	23	....hrs. ....min.

9. Birthplace: Wisconsin (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William E. Roblee
13. Birthplace: Neenah, Wis.

MOTHER
14. Maiden name: Katherine Rohlinger
15. Birthplace: Blackcreek, Wis.

16. Informant: Robert H. Seefeld
Address: 708 Glenmore St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1945 (month) (day) (year)
Cemetery or crematory: Holy Cross Cemetery
Location: Milwaukee, Wis.

19. Funeral director: Charles L. George
Address: Cumberland, Md.

19. May 8, 1945 (Date rec'd by registrar) Wm. R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-6 19 45, at 3:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1, 1945 19..., to 5-6- 19 45 and that I last saw h.. alive on 5-6-45 19...

Immediate cause of death	DURATION
Carcinoma of Gall Bladder	6 mo.
Due to	
Due to	
Carcinomatosis	1 mo.
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Gall B. & Liver
Date of op. 5-3-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. C. Summers M. D. or other
Address: Cumberland Md. Date signed: 5-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Enfield

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04576

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: [redacted]
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4607 Eastwood Ave [redacted] Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. John Sharp

3.(b) Social Security Number: 214-05-6984

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Okie Viering
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): November 6 1889

8. AGE: Years	Months	Days	If less than one day
55	5	7	..... hrs. ..... min.

9. Birthplace: St. Mary's, West Virginia (Town, county, and state)
10. Usual occupation:
11. Industry or business: Bureau of Mines, Baltimore

FATHER
12. Name: Spencer Sharp
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Sarah A. Stewart
15. Birthplace: Missouri

16. Informant: Memorial Hospital
Address: Cumberland,, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.
18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. May 15, 16 45 Winter R. Frantz, M. D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 19 45 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 19 45 to May 13 19 45 and that I last saw him alive on May 13 19 45.

	DURATION
Immediate cause of death: Carcinoma of rectum	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Malignant tumor of rectum. Date of op. April 24-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. D. Reed M. D. or other
Address: Cumberland Date signed 5/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

04578

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, Institution, or street address where death occurred:
Memorial Hospital, Cumberland, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 19 LAING AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Harrison Sirbaugh Jr

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 16, 1933

8. AGE: Years	Months	Days	If less than one day
12	2	14	hrs. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual occupation STUDENT

11. Industry or business

FATHER
12. Name SIRBAUGH, JAMES H.
13. Birthplace MD.

MOTHER
14. Maiden name LANAN, GRACE
15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3 1945 (month) (day) (year)

Cemetery or crematory Davis Memorial Cem

Location Cumberland, Md. (RURAL)

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md

19. June 1 1945 Winters R. Brantz M.D. Registrar
(Date rec'd by registrar)
DR. ENFIELD

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 30, 1945 19 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 19 45 to May 30 19 45 and that I last saw h[illegible] alive on May 30 19 45

Immediate cause of death General Peritonitis — DURATION

Due to Perforated Appendicitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations General Peritonitis

Date of op. 5/29/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cumberland Date signed 5/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

04581

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 years

Hospital, institution, or street address where death occurred: Miners' Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Borden Road

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Elijah Earl Skidmore

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 11 - 1889

8. AGE:

Years	Months	Days	If less than one day
55	5	9	____ hrs. ____ min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Mail Clerk.

11. Industry or business: P.O. Dept.

FATHER

12. Name: Elijah Skidmore

13. Birthplace: Frostburg, Md.

MOTHER

14. Maiden name: Sarah Prosser

15. Birthplace: Frostburg, Md.

16. Informant: Mrs. Mary Parks

Address: Borden Rd. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22-1945 (month) (day) (year)

Cemetery or crematory: Evangelical Lutheran

Location: Frostburg, Md.

16. Funeral director: Jacob D. Fike

Address: Frostburg, Md.

1945-22 (Date rec'd by registrar) 45-Mrs. Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1945, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19__ to May 20 1945

and that I last saw him alive on May 20 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. M. Long M.D. M. D. or other

Address: Frostburg Md. Date signed 5-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04577

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Borden Mines Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town R. D. # 2 Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hayden Anthony Skidmore

3. (b) Social Security Number 212-01-9824

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rose V. Lanes

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) July 15 - 1913

8. AGE:

Years	Months	Days	If less than one day
31	10	11	..... hrs. ..... min.

9. Birthplace Borden Mine, Allegany, Md.

(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Short Factory

FATHER

12. Name Edward Skidmore

13. Birthplace Frostburg, Md.

MOTHER

14. Maiden name Ida B. Bysbore

15. Birthplace Mt. Storm, W. Va.

16. Informant Mary Lou Skidmore

Address 52 Linden St. Frostburg

17. Burial Date thereof 5/29/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Maryland

18. Funeral director Jacob D. Fazenbaker

Address Frostburg, Md.

19. 5-29-45 Mrs. Nancy N. Roe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1945 to May 26 1945 and that I last saw h.. alive on May 25 1945

Immediate cause of death Coronary Thrombosis — DURATION 1 Day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. C. Lane M.D. M. D. or other

Address Frostburg Md Date signed May 28 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04582

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 yrs. 6 mos. 22 da.

Hospital, institution, or street address where death occurred: St. Mary's Terrace

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. St Mary's Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: William Marshall Smith

3. (b) Social Security Number: 216-05-2902

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Stevenson

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): October 23, 1880

8. AGE:

Years	Months	Days	If less than one day
64	6	22	... hrs. ... min.

9. Birthplace: Lonaconing Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Coal Miner (Retired)

11. Industry or business: Georges Creek Coal Co.

FATHER — 12. Name: John Smith

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Margaret Carr

MOTHER — 15. Birthplace: Ireland

16. Informant: Mrs. A. Smith

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing Md.

19. May 17 1945 (Date rec'd by registrar) Dr. Edwin Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15th 1945, at 1.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1943, to May 15 1945 and that I last saw h... alive on May 14 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. (M. D. or other)

Address: Lonaconing, Md. Date signed: May 17 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0-4583

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address where death occurred:
Mineral Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 175 Bowery St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles F. Sonnenburg

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widower

8.(b) Name of husband or wife: Jennie Sonnenburg

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 21, 1865

8. AGE: Years: 79 Months: 10 Days: 17 If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Maryland
(town, county, and state)

10. Usual occupation: Orderly — retired

11. Industry or business: Hospital

FATHER — 12. Name: Charles Sonnenburg

13. Birthplace: Germany

MOTHER — 14. Maiden name: Kathern Kyhne

15. Birthplace: Germany

18. Informant: Mrs. Leona Dayton

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

19. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. 5-11 19 45 — Mrs Nancy B. Roe, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945, at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 9 1945, and that I last saw h[illegible] alive on May 8 1945

	DURATION
Immediate cause of death: Chronic myocarditis	several years
Due to: Arteriosclerosis	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D.
M. D. or other

Address: Frostburg Md. Date signed: 5-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
MAY 14 1965
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

04584

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital Cumberland Md.

How long in hospital or institution? 50 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town 429 N. Cedar St.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cumberland Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Boy Stegmaier

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/28/1945

8. AGE: Years | Months | Days | If less than one day: 50 hrs. 50 min.

9. Birthplace Cumberland Allegany Co., Md.

(Town, county, and state)

10. Usual occupation Plant

11. Industry or business

FATHER — 12. Name Maurice Stegmaier

13. Birthplace Md.

MOTHER — 14. Maiden name Rita Yarnall

15. Birthplace Md.

16. Informant Maurice Stegmaier

Address 429 N Centre St

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)

Cemetery or crematory St Peter & Paul

Location Wayette St Cumb

18. Funeral director Harris Stein Sons

Address Cumberland, Md

19. May 29 1945 Walter L. Bantz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1945 at 5:05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/28/45 19.. to 5/28/45 19..

and that I last saw him alive on 5/28/45 19..

Immediate cause of death	DURATION
Pneumonia	
4 1/2 months	
Due to Malformation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Anderson M. D. or other

Address 4 Greene St Cumberland Md. Signed 5/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (634)

CERTIFICATE OF DEATH

04585

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County SOMERSET

City or town WELLERSBURG

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME CARRIE M. STURTZ

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife ALBERT STURTZ

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) MAY 8, 1895

8. AGE: Years 50 | Months | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name FREDERICK ROBINETTE

13. Birthplace PA.

MOTHER 14. Maiden name BESSIE BROTEMARKLE

15. Birthplace Cumberland Md

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24, 1945 (month) (day) (year)

Cemetery or crematory Lion Memorial Park

Location Cumberland, Md

18. Funeral director Harvey H. Teigler

Address Hyndman, Pa

19. May 23, 1945 (Date rec'd by registrar) Walter R. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 21 19 45 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-45 19.. to May 21 19 45 and that I last saw h.. alive on May 21 19 45

Immediate cause of death	DURATION
Toxic Nephritis	6 days
Due to	
Due to	
Other conditions Psycho-Neurosis	2 months
Toxic Thyroid Adenoma	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John A Topper M.D. M. D. or other

Address Hyndman Pa Date signed May 23, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

1 04586

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waterslife
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Marion M. Judy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: Thomas Judy
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 1878

8. AGE: Years	Months	Days	If less than one day
66	7	-	hrs. min.

9. Birthplace: Lonaconing, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: James Mason
13. Birthplace: Scotland
MOTHER 14. Maiden name: Mary Ballie
15. Birthplace: Scotland
16. Informant: Mrs. Elizabeth Sowers
Address: Klitzmiller Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30, 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing Md.
19. May 30 1945 (Date rec'd by registrar) Dr. E. Offutt (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1945 at 8 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 1926 to May 28 1945
and that I last saw h alive on March 27 1945

Immediate cause of death	DURATION
Cancer of liver	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Halpin M. D. M. D. or other
Address: Lonaconing, Md. Date signed: May 29 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04587

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 240 Bond St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Ina Lillian Valentine

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Frank A. Valentine
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): March 12, 1897

8. AGE: Years	Months	Days	If less than one day
48	1	20	...hrs. ...min.

9. Birthplace: Oldtown Allegany Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home
FATHER 12. Name: Harrison H. Baggs
13. Birthplace: Allegany Co, Md
MOTHER 14. Maiden name: Nancy S. Crabtree
15. Birthplace: Allegany Co, Md
16. Informant: Frank A. Valentine
Address: 240 Bond St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5 1945 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Cumberland, Md.
18. Funeral director: John J. Stofer
Address: Cumberland, Md.
19. May 4, 1945 (Date rec'd by registrar) Winter L. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1945, at 5:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25, 1945, to May 3, 1945
and that I last saw her alive on May 2, 1945

Immediate cause of death	DURATION
Bronchio Pneumonia	7 days
Due to Chronic Nephritis	6 mos
Due to Arteriosclerosis, C.V.D.	years
Due to Uraemia	days
Other conditions Widow — War casualty of son.	

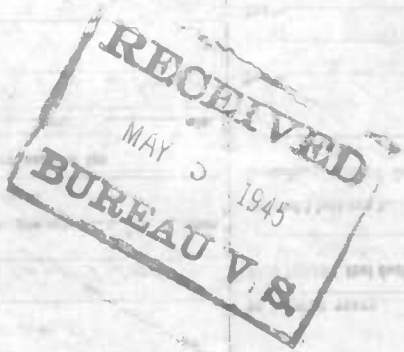
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Clark Jarvis M. D. or other
Address: Cumberland Date signed: 5/3/45

Dr. Burnett


RECEIVED
MAY 5 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-B)

CERTIFICATE OF DEATH

F 04588

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 721 Cecelia St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 721 Cecelia
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Anna Margaret Welch

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John E. Welch
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1892

8. AGE: Years	Months	Days	If less than one day
54	5	8	..... hrs. ..... min.

9. Birthplace: Franklin Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: Wm. Collins
13. Birthplace: Md

MOTHER
14. Maiden name: Ella Carey
15. Birthplace: Md

16. Informant: Mrs. Mary C. Skidmore
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 21 1945 (month) (day) (year)
Cemetery or crematory: St. Patrick's Cem.
Location: Cumberland Md

18. Funeral director: Louis Stein Sec
Address: Cumberland Md

19. 5/19/45 19..... Winter L. Frantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1945, at 8 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1945, to May 15 1945
and that I last saw h... alive on May 15 1945

Immediate cause of death	DURATION
Cerebral hypertension	6 mos
Due to	
Due to	
Other conditions: Arteriosclerosis & Pyuria	2 mos
General Carcinoma (Include pregnancy within 3 months of death)	1 mo

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. L. Owens M.D. M. D. or other
Address: Cumberland Md Date signed 5-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

04589

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

County Hospital

How long in hospital or institution? 4 Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Baltimore St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John E. Wetzel Sr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Imes Wetzel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 30, 1877

8. AGE: Years	Months	Days	If less than one day
68	0	18	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Tailor

FATHER

12. Name: John Wetzel

13. Birthplace: Germany

MOTHER

14. Maiden name: Lisette Bierman

15. Birthplace: Germany

16. Informant: Mrs. Mabel Wetzel

Address: 107 Baltimore St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1945 (month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Cumberland, Md.

16. Funeral director: Charles L. George

Address: Cumberland, Md.

19. May 21 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1945, at 12:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6. 30. 1941, to 5. 18. 1945 and that I last saw h.. alive on 5. 16. 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Unc.
Due to	June 1941
Due to	
Other conditions Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 5.19.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

J 04590

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
52 E Elder St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Elder St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Hallie B. Whisner

3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Chas. N. Whisner
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) March 31 1868
8. AGE: Years 77 Months 1 Days 5 If less than one day ....hrs. ....min.
9. Birthplace W. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Richard J Henry
13. Birthplace W. Va.
MOTHER 14. Maiden name Martha Merchant
15. Birthplace W. Va.
16. Informant Miss Pearl Whisner
Address Cumberland
17. Burial Date thereof May 9 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenway Cem
Location Berkley Springs W. Va
18. Funeral director LOUIS STEIN, INC.
Address Cumberland
19. May 8, 1945 Walter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 3:45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 1944 to May 6 1945
and that I last saw her alive on May 6 1945

	DURATION
Immediate cause of death Coronary disease	2 day
Due to arterio sclerosis	3 y
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Owens M. D. or other
Address 133 Va Ave Date signed 5/6/45

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 04591

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? II DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 919 FREDERICK ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. BERTHA WILLISON

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife SCOTT WILLISON
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APR. 4 1889

8. AGE: Years	Months	Days	If less than one day
56	1	21	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name JOHN SMITH
13. Birthplace Pa
MOTHER 14. Maiden name MINNIE BRAILER
15. Birthplace Pa
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28 1945 (month) (day) (year)
Cemetery or crematory Hillcrest Cem
Location Cumberland Md
18. Funeral director Louis Sloan Sec.
Address Cumberland Md
19. May 26 1945 Winter R. Beauty M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 1945, at 5:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1945, to May 25 1945 and that I last saw her alive on May 24 1945

Immediate cause of death	DURATION
Carbon Embolism	1 day
Etc.	
Due to Auricular Fibrillation	??
Acute Myocardial Dam	?
Due to Hypertensive Arteriosclerosis	3 mos?
Uremia	3 mos.
Other conditions Medical Induced Abortion	?
Hypertensive Heart	?
(Include pregnancy within 3 months of death) Pregnancy Interrupted	?

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodore Jacobson M.D.
M. D. or other
Address 15 S Lukens St Date signed 5/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

T 04592

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 Years

Hospital, institution, or street address where death occurred:
Sylvan Retreat

How long in hospital or institution? 4 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 North Allegany St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Margaret Wise

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 10 1867

8. AGE:

Years	Months	Days	If less than one day
78	3	16	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: Peter Wise
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Wegand
15. Birthplace: Germany

16. Informant: John A. Wise
Address: 121 North Allegany St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 28 1945 (Date rec'd by registrar) Winter R. Trawick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 5-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-5- 1940, to May 26 1945 and that I last saw h[illegible] alive on 5-[illegible]-45 1945

Immediate cause of death	DURATION
Myocardial degeneration	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 5-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. HUNTER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 39-6

04593

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND, County ALLEGANY
City or town ~~near~~ CUMBERLAND, R.F.D. 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. CHARLES, L. WOLFORD

3.(b) Social Security Number 213 - 24 - 6174

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife BERTHA TWIGG

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 21 1874

8. AGE: Years	Months	Days	If less than one day
71		2	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation UNEMPLOYED
11. Industry or business

FATHER
12. Name JACOB WOLFORD
13. Birthplace Maryland

MOTHER
14. Maiden name MARY MORGART
15. Birthplace Pennsylvania

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 25, 1945 (month) (day) (year)
Cemetery or crematory Zion Memorial Park
Location 4 miles east of cumberland. Md

18. Funeral director John A Woolford
Address Cumberland, Md

19. May 24, 1945 Walter L. Brant, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 23, 1945, 19..., 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1945 to May 23, 1945 and that I last saw him alive on May 22, 1945

	DURATION
Immediate cause of death Lobar Pneumonia	
Due to Interstitial Influenza	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Bartley Hunter, M.D. M. D. or other
Address Cumberland Md Date signed 5/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

T 04594

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Enroute to Allegany Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Alleg.
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 112 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: Frank Luther Wood

3.(b) Social Security Number: 705-10-7005

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith Gladden
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jul. 31 1897

8. AGE: Years	Months	Days	If less than one day
47	9	14	hrs. min.

9. Birthplace: Ragland, Ala. (Town, county, and state)
10. Usual occupation: Checker
11. Industry or business: R.R.Co.

FATHER
12. Name: John J.Wood
13. Birthplace: Piedmont, Ala.

MOTHER
14. Maiden name: Ade Chandler
15. Birthplace: Ragland, Ala.

16. Informant: Mrs Edith Wood
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. May 18 19 45 Wm. R. Dent M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION about P.

20. DATE OF DEATH: May 15th. 1945 at 8.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Thrombosis	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis H. Bowen M.D.
Address: Cumberland, Maryland M. D. or other
Date signed: 5-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

F 04595

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 15 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town LONACONNING
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MR. CLARENCE F. WORKMAN

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

8.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) [redacted] April 1, 1875

8. AGE: Years 70 | Months 1 | Days 2 | If less than one day hrs. min.

9. Birthplace MARYLAND Mt Savage, Allegany Co.
(Town, county, and state)
10. Usual occupation CARPENTER
11. Industry or business Own Business
MOTHER FATHER
12. Name WILLIAM C. WORKMAN
13. Birthplace MARYLAND, Near Mt. Savage
14. Maiden name REBECCA SHERIFF
15. Birthplace MARYLAND, Bloomington
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5 1945 (month) (day) (year)
Cemetery or crematory Allegany Cem.
Location Frostburg, Md.
18. Funeral director Ellsworth E. Boal
Address Westernport, Md.
19. May 4, 1945 (Date rec'd by registrar) Winter F. Grantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 3 1945 at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1945 to May 3 1945
and that I last saw h[illegible] alive on May 3 1945
Immediate cause of death Bronchial Pneumonia — DURATION 10 yrs.
Due to
Due to
Other conditions Secondary Syphilis — DURATION Unknown
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address [illegible] Md. Date signed May 7, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15